UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARALAST (alpha-1-proteinase inhibitor)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Diagnosis of Emphysema
- Current treatment
- Treatment failures
- Explanation of condition that demands augmentation with Aralast

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

1 year with documentation of sustained improvement

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